Malaise, Gordon

From: O'Malley, Jim T - DWD <Jim.OMalley@dwd.wisconsin.gov>
Sent: Wednesday, December 11, 2013 4:05 PM
To: Malaise, Gordon
Subject: WCAC AGREED UPON BILL

The Worker's Compensation Advisory Council (WCAC) reached final agreement for statutory and rule changes for this legislative cycle at the meeting on December 3, 2013. On November 20, 2013, I forwarded some of the proposed amendments the WCAC previously agreed to for the "WC Agreed Upon Bill".

For additional background I am forwarding the proposals made by Labor, Management and the Self-Insurers Council (SIC) for this legislative session. The proposals from Labor are in the attachment on the left below. The proposals from Management are in the attachment second from the left below. The proposals from the SIC are in the two (2) attachments on the right.

The WCAC agreed to approve the following proposed amendments to Chapter 102, Stats.

1. s. 102.11 (1) This amendment will increase the permanent partial disability (PPD) weekly rate by $15 for injuries occurring in 2014 after the effective date to $337 and by $15 to $352 for injuries occurring on and after January 1, 2015. We should use the Revisor's insert for the effective date for the PPD rate increase in 2014.

2. s. 102.125 This amendment will authorize the Department of Justice to investigate and prosecute fraud involving worker's compensation. The amendment will provide the Worker's Compensation Division (WCD) will provide funding for the Department of Justice (DOJ) for one (1) FTE position to investigate and prosecute fraud. The funding for this position will be from the WCD operations. The intent is for the DOJ staff to investigate cases of potential fraud and for an assistant attorney general to prosecute fraud similar to what is done in the Unemployment Insurance Division. Fraud prosecutions will not be limited to employees who commit fraud. This amendment will provide that employees, employers, insurance companies and health care providers may be prosecuted. The current s.102.125, Stats., provides that prosecutions are made under s. 943.395, Stats. It may be necessary to add cross references to other statutory provisions in the criminal code for authority to also prosecute employers, insurance companies and health care providers based on

fraudulent activities related to worker's compensation. There should also be an amendment in ch. 20, Stats., for authority for the position and for the Department to fund the position at DOJ.

3. s. 102.13 (2) (b) This amendment will limit the charge for providing copies of medical records in electronic format for a fixed fee of $26.00 per request. This is based on Labor Proposal No. 2 except that the maximum charge is set at $26.00 rather than $20.00 as stated in the original proposal.

4. s. 102.16 (2) (d) The formula amount for determining reasonableness of fee disputes is reduced from 1.2 standard deviations above the mean to .70 standard deviations above the mean. The WCAC agreed to a two (2) step plan for addressing medical costs. The first step is to reduce the formula amount to .70 standard deviations above the mean. This amendment should apply for health care services provided up to the date the fee schedule becomes effective.

5. The second step for addressing medical costs is to establish a fee schedule. I am not sure if the fee schedule should be in s. 102.16, Stats., another section or whether a new section should be created for this. The WCAC directed the Department to establish a medical fee schedule by June 30, 2015. The fee schedule will be based on average group health insurance payments plus ten (10) per cent. The fee schedule will have five (5) geographic regions in the state. The fee schedule will be adjusted annually based on medical CPI. The fee schedule will not go longer than two (2) years before the payment data will be compared to the group health insurance market to update new payment data based on the market at that time. The WCAC will review and approve the fee schedule before it is implemented. The fee schedule will apply for health care services provided beginning July 1, 2015. Payment data to be used in the fee schedule will be obtained from the Wisconsin Health Information Organization (WHIO), Workers Compensation Research Institute (WCRI), state health plan, group health insurers and plans and other credible sources. It may also be necessary to provide statutory authority to promulgate rules for establishing the fee schedule.

6. s. 102.17 (4) The statute of limitations for traumatic injuries will be reduced from 12 years to 9 years. The statute of limitations for occupational diseases will remain at 12 years.

7. s. 102.18 (1) (a) This amendment will authorize administrative law judges to issue prospective orders for proposed (future) vocational rehabilitation training to those employees whose permanent restrictions cannot be accommodated by their employer to within 85% of the employee's pre-injury wage. This is based on Labor Proposal No. 1.

8. s. 102.28 (2) These amendments apply to self-insured employers. In Wisconsin both private sector employers and political subdivisions of the state can become self-insured for worker's compensation purposes. Self-insured status for private sector employers and political subdivisions is covered in DWD 80.60 of the Wisconsin Administrative Code. There is a different process for private sector employers and political subdivisions to become self-insured. The WCAC agreed to create a paragraph in s. 102.28 (2) to include in the statutes the process for political subdivisions to become self-insured. We suggest creating a new paragraph, s. 102.28 (2) (bm) for this purpose. The essential elements and suggested language for this amendment are contained in the attachment appearing second to the right above.

   The WCAC also agreed to amend the self-insurance revocation process for political subdivisions to eliminate the Self-Insurers Council (SIC)from the process because the SIC is not involved in the approving self-insured status for political subdivisions. The amendment will change the process for a political subdivision wanting to become self-insured again after a revocation of self-insured status. With the amendment a political subdivision will no longer be treated like a private sector employer. After a three (3) year period the political subdivision will be permitted to become self-insured again under the political subdivision process with demonstrating to the Department that it is compliant with the WC Act. We suggest creating another paragraph, s. 102.28 (2) (cm), for this. The essential elements and suggested language for this amendment are contained in the attachment appearing second to the right above.

The language in the current statute is ambiguous about whether political subdivisions are liable for assessments for insolvent self-insured employers and whether they are covered by the Self-Insured Employers Liability Fund, s. 102.28 (7) & (8), Stats. It has been the long standing interpretation of the law and the practice of the Department that political subdivisions are not assessed to pay claims for insolvent private sector self-insured employers and are not covered by the Self-Insured Employers Liability Fund. The amendment will make clear that only self-insured employers that are assessed are eligible for coverage by the Self-Insured Employers Liability Fund. We suggest creating another paragraph, s. 102.28 (7) (bm), for this amendment. The essential elements and suggested language for this amendment are in the attachment appearing second to the right above.

9. s. 102.28 (7) (b) This amendment will provide that all assessments against self-insured employers for insolvency will be made on a pro rata basis according to the gross payroll reported to the Department the previous year for unemployment insurance purposes. The assessments are currently based on equal shares for private sector self-insured employers for the first year then on a pro rata basis according to payroll for subsequent assessments. The essential elements and suggested language for this amendment are in the attachment on the far right above.

10. s. 102.42 The WCAC agreed the Department should employ a medical expert on staff. I am not sure where this should be included in ch. 102, Stats., but my best guess is in s. 102.17 or s.102.42. There should also be an amendment in ch. 20, Stats., for authorization for this new FTE position.

11. s. 102.425 The WCAC agreed to a proposal concerning repackaged drugs. If the prescription drug is dispended outside of a retail, mail order or institutional pharmacy is for a repackaged drug, the maximum reimbursement amount shall be calculated using the average wholesale price set by the original manufacturer of the underlying drug which may not be the manufacturer of the repackaged or relabeled drug. If the National Drug Code (NDC) of the underlying drug cannot be determined from the billing, the maximum reimbursement amount shall be calculated using the lowest cost, therapeutically equivalent drug. This proposal is from the first two (2) paragraphs of Management Proposal No 10. It was not agreed to adopt the third paragraph of Management Proposal No. 10 limiting physician dispensing of drugs. Management Proposal No. 10 is in the attachment appearing second to the left above.

12. s. 102.44 (1) (ag), (am) & (b) The WCAC agreed to increase supplemental benefits by moving eligibility and benefit rates forward two (2) years. This will include injury dates occurring in 2001 and 2002. The maximum weekly benefit rate will increase from $582 to $669. Section 102.44 (1), Stats., should be amended as in the past when the supplemental benefit eligibility was moved forward to include more injured employees and increased supplemental benefit rates. The Revisor's insert for the effective date should be used because the effective date is unknown at this time.

13. ss. 102.44 (1) (c) & 102.65 (4) The WCAC agreed to permanently suspend reimbursements for supplemental benefit payments from the Work Injury Supplemental Benefit Fund.

14. The WCAC agreed to provide indexing benefit rate increases after six (6) years for employees collecting permanent total disability (PTD) **or** continuous temporary total disability for more than 24 months. The increase in the benefit rates will be paid for by the insurance companies and employers. The indexing provision will apply to injury dates occurring after June 30, 2015. The proposal is for indexing of the benefit rates similar to the manner in which supplemental benefits are administered, except the benefit increases will be automatic and paid by the insurance companies and employers rather than the Work Injury Supplemental Benefit Fund. The benefit rate increases are to take place beginning six (6) years after the injury date. I am not sure where this amendment should be located in ch. 102. Stats., but the suggestion is to include this in s. 102.43, Stats. This amendment is from Labor Proposal No. 5. This proposal is in the attachment on the far left.

15. Payments for permanent partial disability (PPD) will be increased after 200 weeks. The intent for this amendment is to index (increase) the PPD rate for extended periods of PPD. The PPD rate will increase beginning with the 201st week of PPD to the rate in effect at the time of that payment. Although most employees receive the maximum rate for PPD there are some who do not. Language should also be included that provides that an employee is entitled to receive the same ratio of the new allowable maximum rate as his/her original benefit rate compared to the maximum at the time of injury. The indexing will apply to PPD beginning with the 201st week in both situations where PPD payments are continuous and when additional PPD becomes payable later, such as following a surgical procedure. Under this proposal the PPD rate increase will apply beginning with the 201st week of PPD. With this proposal there will be numerous rate increases in cases where there is a great deal of PPD payable, assuming there are PPD benefit rate increases. For example if 500 weeks of PPD are payable, if there is a higher benefit rate in effect on the 201st week, the PPD rate will increase to that amount: on the 253th week the rate would increase at that point: on the 305th week the benefit rate would increase: on the 357th week the benefit rate would increase, and this would continue until all PPD payments were made. I am not sure where this amendment should be included in ch. 102, Stats. This amendment is from Labor Proposal No. 9. However, the WCAC agreement is to begin increasing the rate after 200 weeks of PPD instead of four (4) years. Labor Proposal No. 9 is in the attachment on the far left. 102.44(3)

16. Employers will be required to maintain group health coverage while employees are off work because of a work-related injury. The intent of this provision is for employers who provide or contribute to payment of health 113.10 (9) insurance coverage or self-funded insurance plan for employees and his/her family members at the time of injury to maintain that coverage under the same terms and conditions for the duration of an employee's healing period. Essential elements of this proposal are: (1) Employers who at the time of injury provide or contribute to payment for health insurance coverage are required to continue this coverage under the same terms and conditions during the employee's healing period. (2) After a work-related injury the employee will be required to continue payments in the appropriate amount to maintain coverage. (3) If an employer does not maintain insurance coverage under the same terms and conditions as at the time of injury, the employer or insurance carrier will be required to pay an employee compensation in an amount equal to 100% of the amount of the employer's previously provided contribution, and this amount will be in addition to temporary disability due for the injury and will not be subject to the maximum limit specified in s. 102.11, Stats. (4) If an employer does not continue to provide the health insurance coverage, an employee may request a hearing to claim 100% of the employer's contribution. (5) The requirement to provide or pay for the health insurance coverage will continue for as long as the employee receives temporary disability (for the length of the employee's healing period) from the injury).(6) The employment status of the worker following the injury will have no effect on the requirement to maintain health insurance coverage. (7) This provision applies to injuries occurring after June 30, 2015. This amendment should probably be included in a new section in ch. 102, Stats. This is from Labor Proposal No.10 and is included in the attachment on the far left.

17. The WCAC also agreed to the creation of a study group that will review and evaluate outcomes of treatment provided to injured employees by health care providers. This should be included in a nonstatutory provision like that included in the last "Agreed Upon Bill", for the study of funding for PTD increases, Section 30 (3), 2011 Wis. Act 183. The committee should include representatives of employers, employees, health care providers, worker's compensation insurers authorized to do business in this state and the Department.

We also request that you amend ch. 20 to authorize the funding and the position authority for the medical expert to be on the Department staff and for the Department to provide funding to the Department of Justice for investigation and prosecution of fraud.

The Department will have a one-time start up Information Technology (IT) expense for updating our computer system to monitor the indexing of PPD payments after 200 weeks. See No. 15 above. At this time we do not have an estimate for this expense. I will forward the amount after it is available.

There will be one more amendment to ch. 102, Stats., that needs to be included in the bill. This amendment is for providing reimbursement to insurance companies for supplemental benefit payments. The amendment will probably be in s. 102.44 (1), Stats. We have not finalized all of the details for the amendment. I hope to forward drafting instructions for this within the next few days.

Let me know if you have any questions.

Thank you for your assistance.

Malaise, Gordon

From: O'Malley, Jim T - DWD <Jim.OMalley@dwd.wisconsin.gov>
Sent: Friday, December 20, 2013 2:35 PM
To: Malaise, Gordon
Subject: FW: WCAC AGREED UPON BILL

Please delete No. 7 below.

The drafting instruction for this point should be that this means of funding supplemental benefit reimbursements will apply to all injury dates before July 1, 2015. The WCAC agreed to permanently provide a cost of living index after six (6) years for PTD claims with injury dates on and after July 1, 2015.

Let me know if you have any questions.

Thank you for your assistance.

From: O'Malley, Jim T - DWD
Sent: Friday, December 20, 2013 2:10 PM
To: Malaise, Gordon - LEGIS
Subject: WCAC AGREED UPON BILL

I am forwarding the final proposal agreed to by the Worker's Compensation Advisory Council (WCAC).

This proposal addresses the solvency of the Work Injury Supplemental Benefit Fund (WISBF) by providing another means of funding supplemental benefit reimbursements. Under this proposal the total amount of supplemental benefit reimbursements will be added to the Department's annual assessment, the reimbursement amount will be paid by insurance companies as part of the annual assessment and the Department will pay the reimbursements from this revenue.

In drafting we would appreciate if the language for this proposal could be drafted in a manner that would not require future amendments.

The essential elements for this proposed legislation are as follows:

1. The money or revenue that will be used to pay the supplemental benefit reimbursements will be from payments made by worker's compensation insurance companies and collected with the annual assessment for the Department's operations. If possible could a term other than "assessment" be used in the amendment?

2. The Work Injury Supplemental Benefit Fund (WISBF) will no longer be responsible to pay reimbursements for supplemental benefits. See No. 13 on the e-mail I sent to you on Dec. 11, 2013.

3. Only worker's compensation insurance companies will be required to make these payments. Self-insured employers will not be required to make these payments. Self-insured employers will not be allowed to claim reimbursement for supplemental benefits.

4. Following the end of a calendar year the Department will determine the total amount due for supplemental benefit reimbursement to WC insurance companies. This amount will be included in the annual assessment. Each WC insurance company will pay its pro rata share of the reimbursement amount. In other words each WC insurance company will pay the on same pro rata basis for the reimbursement as for the regular operations assessment.

5. Supplemental benefit reimbursement payments will be made no later than 16 months after the end of the year in which a claim for reimbursement was received by the Department. Example: For supplemental benefits paid in 2014 the insurer will have until the end of 2015 to claim reimbursement with the Department. After the reimbursement claims are received the Department will know the total amount of reimbursement due. The total amount of reimbursement due will be included in the annual assessment for insurance companies. After the annual assessment is calculated invoices will be sent out in August, 2016. Most assessment payments from the insurance companies will be received by the end of the year in 2016. The intention is for the Department to pay the insurers reimbursement for supplemental benefits by the end of April, 2017.

6. This means of funding payments for supplemental benefit reimbursements will apply to injury dates before July 1, 2015.

7. Reimbursement for any additional or increase in supplemental benefits due beginning July 1, 2015 for injuries before and after that date will not be reimbursed by the Department under this proposal. The Department will reimburse insurance companies for all supplemental benefit due before July 1, 2015.

8. In drafting the language for this proposal sections that may need to be amended include ss. 102.44 (1) (ag) and (c) Stats., 102.65 (2), Stats., and 102.75, Stats. There should also be an amendment to the appropriate paragraph in s. 20.445 (1), Stats.

The estimate for the one-time start up IT expense for updating the Department's computer system to monitor the indexing of permanent partial disability (PPD) benefit payments after 200 weeks is $160,000.

Let me know if you have any questions.

Thank you for your assistance.

Labor Proposals for the Worker's Compensation Agreed Bill – March 12, 2013

Proposal #	Short Title	Brief Description	Current Law	Suggested Statutory Language for the Proposed Change	Rationale
1	Prospective Orders for Retraining	Grant ALJ's the authority to issue a prospective order for proposed periods of retraining.	Under current law, there is no clear authority for an ALJ to issue an order for the respondent employer/carrier to pay for an approved but not yet commenced program of retraining.	Expand existing language in 102.18 (1)(a) (that currently allows ALJ's to issue prospective orders for medical treatment) with: "The department may include in any interlocutory or final award or order an order directing the employer or insurer to pay for any future treatment that may be necessary to necessary to cure and relieve the employee from the effects of the injury, *and may include an order directing that the employer or insurer shall pay for the expense of and compensation for a future course of training under an established plan of rehabilitative training under sec. 102.61."*	This proposal neither increases nor decreases compensation awarded or denied in any individual case, but allows the parties to have the matter of future vocational training adjudicated by the ALJ. To request a prospective order for vocational retraining benefits, the applicant would have to have either an IPE (Individualized Plan for Employment) from the DVR (for seeking retraining and being served by DVR – "public" program under 102.61.(1)(1g)(c)), or a proposed "rehabilitative training program" (RTP) as developed by a private rehabilitation counselor (for those seeking retraining and not served by DVR – the "private" program described in 102.61 (1m)(a)). These required items (IWP, RTP) are already required by the DWD in the Certificate of Readiness process before a retraining benefit claim can be set for hearing.
2	Electronic medical records	Allow medical providers to provide copies of medical records in electronic format for a fixed per request fee of $20.	Under current law, established before the onset of electronic records, medical providers are required to furnish copies at a rate of 45 cents per page, with a	Modify existing language in 102.13(2)(b): "[the medical provider] shall furnish a legible, certified duplicate of the written material requested under par. (a) upon payment of the actual costs of preparing the certified duplicate, not	The current WC statute governing the costs of obtaining medical records was created in the late 1980s-early 90s, the electronic stone age, when virtually all medical records were maintained in physical paper format. The Council adopted a statute that established a set, reasonable rate for paper records provided, based on the number of pieces of paper that

			$7.50 minimum charge, plus postage costs.	to exceed the greater of 45 center per page *of printed records* or $7.50 per request, plus the actual costs of postage." *"In lieu of providing records in paper form, the records may be provided upon electronic media or other readily available and accessible electronic form at a fixed charge of $2~~0~~ per request."* $26	had to be copied, a charging regimen that made sense for a paper world. Some medical providers are now providing records in electronic (CD) form, but charging for the content on the CD on a per page basis, affecting the costs of obtaining needed medical records for both applicants and employers/insurers. The cost for the medical record provider to create a CD of 1 or 1000 PDF pages is identical, but what some medical record providers now attempt to charge is, under current law, set by "pages" of records. Thus, under current law, medical records custodians with 300 pages of records in electronic medical records format can create, with a few mouse clicks, a CD of PDF's of the medical records and attempt to bill the requester $135. Being allowed to provide records as PDFs, yet billing on a per page basis of $135 (45 cents per record page) for the CD, shifts the cost of converting the record to paper form for case evidence use (for which the 45 cents per page fee was intended to cover) from the provider receiving the copying fee to the requesting party. This change would restore the cost equity between medical providers and medical record requesters as originally intended, and would also encourage the greater use of electronic medical records.
3	Pharmacy fee schedule applied to medications dispensed by	Payment rate for medications unchanged but repackaged at amedical provider	Under current law, a health care provider may purchase prescription medications for dispensing to the injured	Labor suggests the DWD develop the language in collaboration with individuals experienced with the application of such rules used in other states.	Under current law, prescription medications dispensed by a pharmacy are subject to a pharmacy fee schedule under sec. 102.425. Certain health care providers may dispense prescription medications directly to the injured worker at their offices, repackaging the

	health care providers	facility shall only be paid at the pharmacy fee schedule rate.	employee, with such dispensing/repackaging not being subject to the pharmacy fee schedule.		medications and charging higher prices for the same medication that could be dispensed by the nearby pharmacy and that would be subject to the pharmacy fee schedule. This provision would apply the pharmacy fee schedule to such health care provider office provided medications.
4	Surgical implant fee formula	Payment rate for surgical implants based on actual cost pricing plus appropriate markup.	Under current law, there is no fee schedule or database for surgical implants.	Labor suggests the DWD develop the language in collaboration with individuals experienced with the application of such rules used in other states.	Under current law, there is no process for a "reasonable" fee charged for an implanted device. This would establish a limitation on pricing for such implanted devices based on the provider's invoice cost for the device (after all discounts or rebates applied) plus a 10% markup over the net cost.
5	PTD rate indexing	Provide indexing of PTD benefit rate after 6 years, paid for directly by employer/carrier for injuries occurring after 1/1/2014	Current law provides for the indexing of PTD benefit rates, after a time (subject to biannual negotiations, a currently 12 year lag, but had been as low as 8 years, or as many as 16 years), with any amount paid over and above the date of injury rate paid by the Supplemental Benefit Fund.	Create sec. 102.43(10)(a): *"Notwithstanding any other provision of this chapter, for every employee who is receiving compensation under this chapter for permanent total disability or continuous temporary total disability more than 24 months after the date of injury, resulting from injury occurring after January 1, 2014, payment of compensation under this chapter for periods of disability occurring more than 6 years from the date of injury shall be made as provided in par. (b)."* Create 102.43(7)(c)1: *"If the employee was entitled to maximum weekly benefits at the time of injury, payment for weekly benefits*	The current funding source for indexed PTD benefits is the financially troubled Supplemental Benefit Fund. This would shift the cost of future PTD rate indexing increases to the employer/carriers, and would allow carriers to account for such cost in establishing the overall premium charged to the employer. This provision would take effect only for injuries occurring on or after 1/1/2014. The intent is to index the PTD benefits to the rate of current benefits with a 6 year lag. Those with injuries occurring before 01/01/2014 would continue to receive benefits as provided by current law.

				occurring more than 6 years after the injury shall be at the maximum rate in effect at the time of accrual of payment of benefits ." Create 102.43(7)(c)2: *"If the employee was entitled to less than the maximum rate, the employee shall received the same proportion of the maximum which is in effect at the time of the accrual of payment of benefits."*	
6	Suspend reimbursements to carriers for supplemental benefit payments, and establish a 6 year time lag between injury and indexing.	Curtail the drain on the Supplemental Benefit Fund by eliminating one outflow of payments. Also establish the long requested goal of a 6 year lag.	Current law provides that the PTD benefits paid to employees are indexed after a time (currently 12 year lag), with supplemental benefits paid in the first instance by the carriers/employers but later reimbursed to the carriers/employers from the Supplemental Benefit Fund.	Amend section 102.44(1)(c) to add: *"This subsection is suspended beginning 01/01/2014."* Amend section 102.44(1)(ag) to read: "Notwithstanding any other provision of this chapter, every employee who is receiving compensation under this chapter for permanent total disability or continuous temporary total disability more than 24 months after the date of injury that occurred prior to January 1, *2006*, shall receive supplemental benefits that shall be payable in the first instance by the employer or the employer's insurance carrier, or in the case of	The current funding source for indexed PTD benefits is the financially troubled Supplemental Benefit Fund (SBF). This proposal would reduce the outflow of monies from the SBF by suspending this reimbursement to carriers for the supplemental benefits paid those PTD by injuries occurring before 1/1/2014. This proposal would help to shore up the finances of the financially troubled SBF. This proposal would also establish the 6 year lag between date of injury and PTD indexing.

				benefits payable to an employee under 102.66, shall be paid by the department out of the fund created under s. 102.65. These weeks of disability shall be paid only for weeks of disability occurring after January 1, *2008*, and shall continue during the period of such total disability subsequent to that date. *This subsection shall apply only to those employees suffering injury before 01/01/2014.*	
7	SSDI offset reduction savings to SBF	Provides that any reduction in benefits rates due to the application of Social Security Disability offset inures to the benefit of the Supplemental Benefit Fund.	Current law limits the employee's combination of WC benefits and SSDI benefits to 80% of the employees prior earnings, with indexing. If the combination of WC and SSDI would exceed 80%, the WC benefit is reduced. (In most states, the SSDI benefit is the one reduced, WI is a "reverse offset state.")	Expand the current SSDI offset statute, sec. 102.44(5) to include: *"(h) Any reduction in benefits otherwise payable to the injured employee taken by the employer or self-insured employer by virtue of this section shall be paid to the fund established in sec. 102.565."*	Current law allows the employer/carrier to reap a savings from the fact that the work injury has rendered the employee so disabled that the employee qualifies for Social Security Disability Benefits (SSDI). Under this proposal, any savings from a reduction in WC benefits by application of the SSDI offset formula would be paid instead by the carrier to the Supplemental Benefit Fund. This would help to shore up the finances of the financially troubled SBF.
8	PPD max rate increase	Increase Permanent Partial Disability Max rate	Current max PPD rate of injuries occurring in 2012 is $312, for 2013 it is $322.	For injuries in 2014, set max PPD rate at $337. For injuries in 2015, set max PPD rate at $352.	Keep maximum Permanent Partial Disability (PPD) rates in line with increases in cost of living and at a reasonable proportion of maximum TTD rates. TTD rates are set automatically, PPD rates are negotiated every agreed bill. Not all workers receive max PPD

					rates for their injury, but are limited to 2/3rds of average weekly wage at time of injury, and this proposal does not change that aspect of current law.
9	Index PPD rate for extended periods of PPD	Index PPD rate for increased permanent disability occurring more than 4 years after the date of injury	Under current law, PPD rates are fixed on the date of injury. Under current law, TTD rates are fixed on the date of injury, but current law also provides for TTD rate increases for certain periods of renewed temporary disability more than 2 years post injury. With this proposal, PPD paid more than 4 years after the date of injury would be paid at the PPD rate in effect at the time of payment	To be drafted	Unlike TTD and PTD benefits which are adjusted under current law to reflect inflation, PPD rates under current law remain fixed no matter how long after the injury renewed payments are made. For example, an employee sustaining a knee in 1990, initially suffering a meniscal injury with typical repair, would typically receive 5% PPD at the 1990 rate of $131 per week, $2,783.75. Twenty years later, if the employee requires a total knee replacement due to the injury, the additional PPD benefits of 50% at the knee, 212.50 weeks of PPD, are now paid at that $131 per week, or $21,875. This proposal would increase the PPD to the rate being paid for current injuries if the renewed period of PPD occurs more than 4 years after the date of injury. Under this example, a knee replacement occurring in 2013 causing a renewed period of entitlement to PPD benefits would be paid at the rate of $322 per week, or $68,425.
10	Compensation for loss of medical insurance coverage		Under current law, the TTD rate is set based on the average weekly wage (AWW), and AWW does not account for the value of fringe benefits. Under current WC law, the employer is not required to maintain the	Create sec. 102.43(12) to provide: "If at the time of injury an employer provides or contributes to the payment for general health insurance coverage, or an equivalent self funded insurance plan, which provides medical expense coverage to a worker or the worker and his family members, and during the	Under current law, the employee suffering temporary disability receives 2/3rds of his AWW at the time of injury, a rate historically established to provide the employee with roughly his take home wages at the time of injury, as TTD benefits are not subject to taxation. Historically, the portion of the overall employee compensation package that was the provision of health insurance was relatively small, but in today's world, the cost of the health insurance provided by the employer

			employee's group health insurance while the employee is off work due to the work injury, nor to pay any compensation for this portion of the employee's overall compensation package for employment.	period of temporary disability the employer contribution to such general health insurance or self fund equivalent coverage ceases, the employer and carrier are liable to pay to the employee additional compensation equal to 100% of the amount of the employer's previously provided contribution for such group health insurance or self funded equivalent coverage. Such payment shall be made for as long as the employee remains in a period of temporary disability from the injury. Such compensation is in addition to any temporary disability due, and is not subject to the maximums set forth in sec. 102.11.	makes up a far greater share of the overall employee compensation package. For the lower hourly wage employee, the value of employer provided health insurance may well exceed the value of hourly pay for his work. Some employers, following a work injury, continue to make their typical contributions towards the worker or the worker and his family general group health insurance or equivalent ERISA plan. Some employers, however, cease making such contribution as soon as possible, generally 12 weeks after injury (with 12 weeks of coverage provided under FMLA). Once the employer contribution ends, the employee is left with the "option" of paying out of his TTD benefits the group insurance/ERISA plan premium cost, at a cost that at times can almost equal the full amount of his TTD benefits. This proposal would remedy this inequity by providing additional compensation to the employee for the loss of group health insurance/ERISA coverage during the period of temporary disability. If the employer continues to provide, during the period of temporary disability, the same group health insurance coverage that the employee would have had but for the injury, no additional benefit is triggered. Under this proposal, the employee continues to be responsible for whatever his contribution towards the cost of such group health insurance would have been but for the injury.
11	Medical expense liability equity.	Require DWD hearing awards for	Under current line of LIRC case law, beginning	Create sec. 102.18(1)(bg)4 to provide:	Current LIRC case law gives the insurance carrier/employer the benefit of adjustments to medical

		medical expense to provide the health care provider the same remuneration for medical care whether it is a conceded claim or disputed case won by the applicant at hearing. Provide an attorney for applicant counsel limited to 20% of medical expenses that are unpaid/unadjusted as of the time of hearing.	with *Hoefs v. Midway Hotel*, WC Claim No. 1999-029146 (LIRC 2003), if the applicant prevails on medical expense at hearing, the amount awarded to the medical provider is less than the amount that would have been paid to the medical provider had the case never been contested. Under *Hoefs* and subsequent cases, the LIRC has given the respondent the benefit of adjustments/write-offs listed on medical bills.	If the department finds under par. (b) that an insurer or self-insured employer is liable under this chapter for any health services provide to an injured employee by a health service provider, the order shall provide for payments as follows: a) that the employer or self-insured employer shall pay to the health care provider, the total amount charged for the provider's services (or the lesser amount if determined under the provisions of s.102.16(2)), less any amounts previously paid towards the bill by the employee; but if the employee is represented by an attorney at hearing, an additional reduction to the provider equal to 20% of the amount of the healthcare providers bill left unpaid as of the time of hearing, after deductions for group health insurance payments and adjustments; b) that the employer or self-insured employer pay to the employee any amounts the employee previously paid towards the medical expenses; c) that the medical provider shall reimburse to any other entity having previously made payments to the medical	bills on the basis of a medical providers receipt of group health insurance. This creates a financial incentive for an employer/carrier to deny a claim soley to obtain the cost savings of group health adjustments to medical bills. A case in which liability is conceded, and a case in which liability is disputed and lost by the employer at hearing, should result in the employer/WC insurance carrier identical liability, but under current LIRC case law the employer/WC carrier pays out less overall from taking a case to hearing and losing they would have had the claim been conceded. The medical provider is the party that loses out on this inequity. This proposal would restore equity and eliminate the incentive of the employer/carrier to deny claims simply on the expectation of reaping a savings from medical bill adjustments. This proposal would also resolve the long standing debate on awarding attorney fees on unpaid medical expenses.

				provider toward such medical expense; and d) to the applicant's attorney, an amount equal to 20% of the unpaid and unadjusted balances for such services as of the time of hearing.	
12	Remove sunset provision from 102.43(5)(c)	Makes the change enacted allowing for part time work while retraining permanent			The 2012 Agreed Bill provided for no reduction of TTD benefits for part time work while retraining, but provided a two year sunset on the provision. This would remove the sunset, and make the change permanent.

Issue A: Insolvency Assessment Formula

Assessments are currently equal shares the first year, then pro rata by payroll any subsequent years. Some self-insurer families have subsidiaries with no, or few, employees, and consider it unfair to receive the same assessment as an employer with thousands of employees. This perceived inequity has led at least one family of employers to refuse self-insurance authority. Presumably, the equal shares method was chosen many years ago for simplicity and speed of calculating assessments. At present it is easy for the department to calculate assessments on a pro rata basis. The following changes are recommended to make all insolvency assessments pro rata by payroll.

102.28(7) INSOLVENT EMPLOYERS; ASSESSMENTS. (a) If an employer who is currently or was formerly exempted by written order of the department under sub. (2) is unable to pay an award, judgment is rendered in accordance with s. 102.20 against that employer, and execution is levied and returned unsatisfied in whole or in part, payments for the employer's liability shall be made from the fund established under sub. (8). If a currently or formerly exempted employer files for bankruptcy and not less than 60 days after that filing the department has reason to believe that compensation payments due are not being paid, the department in its discretion may make payment for the employer's liability from the fund established under sub. (8). The secretary of administration shall proceed to recover such payments from the employer or the employer's receiver or trustee in bankruptcy, and may commence an action or proceeding or file a claim therefor. The attorney general shall appear on behalf of the secretary of administration in any such action or proceeding. All moneys recovered in any such action or proceeding shall be paid into the fund established under sub. (8). 143

(b) Each employer exempted by written order of the department under sub. (2) shall pay into the fund established by sub. (8) an initial assessment based on orders of the department with assessment prorated on the basis of the gross payroll for this state of the exempt employer, reported to the department for the previous calendar year for unemployment insurance purposes under ch. 108. If the exempt employer is not covered under ch. 108, then the department shall determine the comparable gross payroll for the exempt employer. ~~a sum equal to that assessed against each of the other such exempt employers upon the issuance of an initial order~~. The order shall provide for a sum sufficient to secure estimated payments of the insolvent exempt employer due for the period up to the date of the order and for one year following the date of the order and to pay the estimated cost of insurance carrier or insurance service organization services under par. (c). Payments ordered to be made to the fund shall be paid to the department within 30 days. If additional moneys are required, further assessments shall be made based on orders of the department with assessment prorated on the basis of the gross payroll for this state of the exempt employer, reported to the department for the previous calendar year for unemployment insurance purposes under ch. 108. If the exempt employer is not covered under ch. 108, then the department shall determine the comparable gross payroll for the exempt employer. If payment of any assessment made under this subsection is not made within 30 days of the order of the department, the attorney general may appear on behalf of the state to collect the assessment.

DWD 80.40 Assessment for unpaid claims of insolvent self-insurer. If an employer currently or formerly exempted from the duty to insure by order of the department under s. 102.28 (7) (b), Stats., is unable to pay any award and if judgement against such employer is returned unsatisfied, the department shall determine payment into the fund established by s. 102.28 (8), Stats., as follows:

(1) The department shall prepare an estimate of the payments that should be made by the insolvent exempt employer for a period of one year. If the department elects to retain an insurance carrier or insurance service organization under s. 102.28 (7), Stats., the department will prepare an estimate of the charges that will be made by such carrier or organization to process, investigate and pay such claims for the same one year period. The sum of these 2 amounts shall be divided ~~by the total number of~~ amongst the employers exempted under s. 102.28 (2), Stats. In a pro rata share determined as provided by s. 102.28 (7) (b), Stats.

(2) The department shall assess and order payment within 30 days by each exempt employer the amount determined under sub. (1) to the state treasurer for deposit in the fund created by s. 102.28 (8), Stats.

(3) The department shall prepare an estimate of the total remaining liability of the insolvent exempt employer and an estimate of the amount that may be recovered from that employer, its receiver or trustee in bankruptcy. Such estimates shall be communicated to all exempt employers.

(4) At least annually following the original order the department shall estimate the amount due and payable during the following year and the charges expected from any insurance carrier or claims service for such year and assess and order payment by each exempt employer its pro rata share determined as provided by s. 102.28 (7) (b), Stats.

(5) At the time orders are issued under sub. (4) the department shall prepare an estimate of the remaining liability of the insolvent exempt employer and the amount that may reasonably be expected to be recovered from such employer, its receiver or trustee in bankruptcy. Such estimates will be communicated to all exempt employers.

(6) All money due and payable to injured employees which remain unpaid shall be considered money payable during the following year in making estimates.

(7) All money recovered by the attorney general and paid into the fund shall be used in the payment of unpaid claims and shall be taken into account in making estimates and assessments.

History: Cr. Register, September, 1986, No. 369, eff. 10-1-86.

Issue G: Insolvent Employer Assessments and Political Subdivisions

First, while self-insurance for political subdivisions is addressed in code, there does not appear to be statutory authority, so a new section s. 102.28(2)(cm) is created.

Second, the revocation process is amended to eliminate the Self-Insurers Council from the process, since that body has no oversight of political subdivisions. In addition, the path for a political subdivision desiring to undertake self-insurance after a revocation is changed. Instead of being treated like a private sector applicant, the political subdivision would, after a three year wait, be permitted to self-insure under the political subdivision rules upon demonstrating to the department that it is compliant with the Act.

Third, existing language is ambiguous on applicability of insolvent employer assessments and coverage under the Self-Insured Employers Liability Fund. It is the intent, and has been the practice, of the department that political subdivisions are not assessed to pay claims of a defaulted private sector self-insurer. It is also implied that only employers that can be assessed are eligible for coverage under the Self-Insured Employers Liability Fund. New language is added to make this explicit.

80.60(3) REQUIREMENTS FOR THE STATE AND ITS POLITICAL SUBDIVISIONS. (a) The state and its political subdivisions may self-insure without further order of the department, if they are not partially-insured or fully-insured, or to the extent they are not partially-insured by written order under s. 102.31 (1), Stats., under one or more policies, and if they agree to report faithfully all compensable injuries and agree to comply with ch. 102, Stats., and the rules of the department. However, any such employer desiring partial-insurance or divided-insurance must submit an application to the department and be given special consent as described in s. DWD 80.61.

(b) 1. Any political subdivision or taxing authority of the state electing to self-insure shall notify the department in writing of the election before undertaking self-insurance, every 3 years after the initial notice, and 30 days before withdrawing from the self-insurance program.

2. The notice of election to self-insure shall be accompanied by a resolution, adopted by the governing body and signed by the elected or appointed chief executive of the applying political subdivision or taxing authority, stating its intent and agreement by the governing body to self-insure its worker's compensation liability and an agreement to faithfully report all compensable injuries and to comply with ch. 102, Stats., and the rules of the department in accordance with s. 102.28 (2) (bm) and (c), Stats.

(c) Self-insurance granted under par. (a) is subject to revocation under s. 102.28 (2) (c), Stats. Once the privilege of self-insurance is ~~revoked, further self-insurance may be authorized only under the procedures set forth in sub. (4)~~revoked, the election to self-insure under (3)(a) may not be undertaken again until at least 3 calendar years have elapsed since the revocation and ~~,~~the department finds that the employer's financial condition is adequate to pay its employees claims for compensation, that the employer has not received an excessive number of claims for compensation, and that the employer has discharged faithfully its obligations under chapter 102, Stats.

Create a new section of statute, basically repeating 80.60(3) to create statutory authority for political subdivisions to self-insure, and to have a statute to refer to when making clear that political subdivisions are not assessed for defaults, nor are they able to have the Self-Insured Employers Liability Fund pay their claims.

102.28(2)(bm) *Exemption from the duty to insure for the state and its political subdivisions.* The state and its political subdivisions may self-insure without further order of the department, if they are not partially-insured or fully-insured, or to the extent they are not partially-insured by written order under s. 102.31 (1), Stats., under one or more policies, and if they agree to report faithfully all compensable injuries and agree to comply with ch. 102, Stats., and the rules of the department. However, any such employer desiring partial-insurance or divided-insurance must submit an application to the department and be given special consent as described by rule.

1. Any political subdivision or taxing authority of the state electing to self-insure shall notify the department in writing of the election before undertaking self-insurance, every 3 years after the initial notice, and 30 days before withdrawing from the self-insurance program.

2. The notice of election to self-insure shall be accompanied by a resolution, adopted by the governing body and signed by the elected or appointed chief executive of the applying political subdivision or taxing authority, stating its intent and agreement by the governing body to self-insure its worker's compensation liability and an agreement to faithfully report all compensable injuries and to comply with ch. 102, Stats., and the rules of the department in accordance with s. 102.28 (2) (b) and (c), Stats.

3. Self-insurance granted under par. (bm) is subject to revocation under s. 102.28 (2) (cm), Stats. Once the privilege of self-insurance is revoked, the election to self-insure under this paragraph may not be undertaken again until at least 3 calendar years have elapsed since the revocation and the department finds that the employer's financial condition is adequate to pay its employees claims for compensation, that the employer has not received an excessive number of claims for compensation, and that the employer has discharged faithfully its obligations under chapter 102.

102.28(2)(a) *Duty to insure payment for compensation.* Unless exempted by the department under par. (b), (bm) or sub. (3), every employer, as described in s. 102.04 (1),137 shall insure payment for that compensation in an insurer authorized to do business in this state. A joint venture may elect to be an employer under this chapter and obtain insurance for payment of compensation. 138 If a joint venture that is subject to this chapter only because the joint venture elected to be an employer under this chapter is dissolved and cancels or terminates its contract for the insurance of compensation under this chapter, that joint venture is deemed to have effected withdrawal, which shall be effective on the day after the contract is canceled or terminated.

Create a new section:

102.28(7)(bm) An employer currently or formerly exempted from the duty to insure under sub. (2)(bm) shall not be assessed under this subsection and no payment shall be made for the employer's liability from the fund established under sub. (8).

102.28(7)(b) Each employer exempted by written order of the department under sub. (2)(b) shall pay into the fund established by sub. (8) a sum equal to that assessed against each of the other such exempt employers upon the issuance of an initial order. The order shall provide for a sum sufficient to secure estimated payments of the insolvent exempt employer due for the period up to the date of the order and for one year following the date of the order and to pay the estimated cost of insurance carrier or insurance service organization services under par. (c). Payments ordered to be made to the fund shall be paid to the department within 30 days. If additional moneys are required, further assessments shall be made based on orders of the department with assessment prorated on the basis of the gross payroll for this state of the exempt employer, reported to the department for the previous calendar year for unemployment insurance purposes under ch. 108. If the exempt employer is not covered under ch. 108, then the department shall determine the comparable gross payroll for the exempt employer. If payment of any assessment made under this subsection is not made within 30 days of the order of the department, the attorney general may appear on behalf of the state to collect the assessment.

80.61(1)(b) "Partial-insurance" means self-insurance of a part of the liability and consent to the issuance of one or more policies on the remainder of the liability, as provided in ss. 102.28 (2) (b), (bm) and 102.31 (1), Stats.

Create a new section:
102.28(2)(cm) *Revocation of exemption.* The department~~, after seeking the advice of the self-insurers council,~~ may revoke an exemption granted to an employer under par. (bm), upon giving the employer 10 days' written notice, if the department finds that the employer's financial condition is inadequate to pay its employees' claims for compensation, that the employer has received an excessive number of claims for compensation or that the employer has failed to discharge faithfully its obligations ~~according to the agreement contained in the application for exemption~~under ch. 102, Stats. The employer may, within 10 days after receipt of the notice of revocation, request in writing a review of the revocation by the secretary or the secretary's designee and the secretary or the secretary's designee shall review the revocation within 30 days after receipt of the request for review. If the employer is aggrieved by the determination of the secretary or the secretary's designee, the employer may, within 10 days after receipt of notice of that determination, request a hearing under s. 102.17. If the secretary or the secretary's designee determines that the employer's exemption should be revoked, the employer shall obtain insurance coverage as required under par. (a) immediately upon receipt of notice of that determination and, notwithstanding the pendency of proceedings under ss. 102.17 to 102.25, shall keep that coverage in force until another exemption under par. (bm) is granted.

STATUTORY CHANGES APPROVED BY WCAC FOR 2014

1. Definition of "municipality" will be amended to include special purpose district, political subdivision and taxing authority of the state. s. 102.01 (2) (d)

2. Authorize technical colleges defined under ch. 38, Stats., colleges defined under ch. 36, Stats, higher education institutions and post secondary education institutions to accept WC liability for students performing services in work training and work experience. Exclusive remedy protection will be extended to employers who provide the work training or work experience. ss. 102.07 (12m) and 102.077 (1) & (2)

3. The weekly PPD rate will increase by $15 to $337 for injuries in 2014 after effective date and to $352 for injuries occurring in 2015. s. 102.11 (1)

4. The Department of Justice (DOJ) will be authorized to prosecute fraudulent activities by employees, employers, insurance carriers and health care providers. s. 102.125

5. Fees for providing medical records in electronic format will be limited to $26 per request. s. 102.13 (2) (b)

6. A treating practitioner's final report will not be required in cases where the claim is completely denied. s. 102.13 (2) (c)

7. The formula amount used to determine reasonableness of fee disputes is reduced from 1.2 standard deviations above the mean to .7 standard deviations above the mean. s. 102.16 (2) (d)

8. The Department will establish a medical fee schedule by June 30, 2015. The fee schedule will be based on group health average rates plus 10 percent, with five (5) geographic regions in the state. The fee schedule will be adjusted annually based on the medical CPI and will be reviewed each two (2) years by the WCAC. Data for the group heath payments will be from the Wisconsin Health Information Office (WHIO), Workers Compensation Research Institute (WCRI), group health insurers and plans and other credible sources.

9. The statute of limitations will be reduced to 9 years for traumatic injuries and remain at 12 years for occupational diseases. s. 102.17 (4)

10. ALJs will be authorized to issue prospective orders for vocational rehabilitation training for employees whose permanent restrictions cannot be accommodated to 85% of pre-injury earnings. s. 102.18 (1) (a)

11. Appeals of orders awarding or denying compensation are to be filed only with LIRC and the standard for LIRC to review late appeals is clarified. s. 102.18 (3)

12. The time during which LIRC may set aside an order for further consideration runs from the date of LIRC's order. LIRC may send orders to the parties other than by mail in the future. s. 102.18 (4)

13. The party who files an appeal of a LIRC decision to the Circuit Court shall be named as the plaintiff and shall name as defendants LIRC and those persons or entities identified by LIRC in its decision as necessary to be named as a party for the appeal to court. s. 102.23 (1)

14. The process for political subdivisions of the state to become self-insured for WC purposes will be included in the statute. This change will clarify the Self-Insurers Council (SIC) is not involved with the self-insured status of political subdivisions. Political subdivisions will not be assessed for insolvent private sector self-insured employers and are not entitled to payments from the Self-Insured Employers Liability Fund. s. 102.28 (2)

15. All assessments made against private sector self-insured employers for insolvencies will be made on pro rata basis according to payroll. s. 102.28 (7)

16. The Department will have and maintain on its staff a medical expert.

17. When a prescription drug is dispensed outside a retail, mail order or institutional pharmacy the maximum reimbursement amount shall be calculated using the average wholesale price (AWP) set by the original manufacturer of the underlying drug which may not be the manufacturer of the repackaged drug. If the National Drug Code (NDC) of the underlying drug cannot be determined from the billing the maximum reimbursement amount shall be calculated using the lowest cost therapeutically equivalent drug. s. 102.425

18. The sunset will be extended for two (2) additional years on the provision that permits employees to work at part-time employment up to 24 hours per week while attending instruction for vocational rehabilitation training without an offset on retraining benefits. s. 102.43 (5) (c)

19. Supplemental benefits will be moved forward two (2) years to include injuries occurring in 2001 & 2002 with the maximum weekly benefit rate increased to $669. Reimbursement for supplemental benefits will be permanently suspended. The Management members of the WCAC will recommend a means of providing

funding for outstanding supplemental benefit reimbursement requests. s. 102.44 (1)

20. There will be indexing for compensation for permanent total disability (PTD) after six (6) years that will be paid by insurance carriers and self-insured employers for injuries occurring on and after July 1, 2015.

21. There will be indexing of payments for permanent partial disability (PPD) after 200 weeks.

22. Beginning July 1, 2015 employers who provide health insurance coverage for employees at the time of injury will be required to maintain that coverage under the same conditions for the duration of an employee's healing period.

23. An added measure of solvency is created for the Uninsured Employers Fund (UEF) to make up for large claims in excess of $1,000,000 that are not covered by excess or stop-loss insurance.

24. The WCAC will create a committee to review and evaluate treatment outcomes from health care providers.

(JOM 12.5.13)

Worker's Compensation Advisory Council
2013-2014

Management Proposals
(3/12/13)

1. Where an employer has a written substance abuse testing policy that is reasonable, uniformly enforced, and in place at the time of an accident, an employee who is injured and who fails a post-accident drug/alcohol test will be denied indemnity benefits.

2. Establish a medical fee schedule that uses Medicare rates as the basis for the schedule. Providers to be paid at 175 percent of the then-current Medicare rate.

3. Allow for Employer-directed care for the first ninety (90) days. Where there is a union agreement covering the workplace, allow Labor and Management to negotiate regarding this provision, to agree upon a panel of providers, and to create incentives for the use of the agreed-upon panel of providers.

4. Reduce the statute of limitations from twelve (12) years to three (3) years.

5. Following a review of the treatment guidelines, implement the guidelines as treatment parameters. For treatment outside the scope of the parameters or alternate treatments, require that the treating physician contact the carrier/self-insured to discuss the treatment plan with a medical professional before such care is provided. If the carrier/self-insured denies further care, it shall state the reasons why in writing. The treating physician can appeal the decision of the carrier/self-insured to the Department.

6. For injured workers receiving indemnity benefits, there shall be a Social Security offset applicable at age sixty-seven (67), the time at which the injured worker begins to receive Social Security retirement benefits, or five (5) years from the date of injury, whichever is later.

7. As a condition of receiving benefits, all initial reports of injuries must be made by employees within one (1) year of the date of a traumatic injury.

8. Where an injury results in PPD and medical evidence shows that there was a pre-existing condition or disability already present in the claimed body part, apportionment shall be made. The employer/carrier will be responsible only for the amount of permanent disability resulting directly from the work-related injury.

9. The status of all PTD recipients shall be reviewed every three (3) years by the Department and the Department shall report to all carriers/self-insureds the name and address of any employers who have reported wage income for an individual receiving PTD benefits. Where there is W-2 wage income or where the injured worker is receiving Social Security (disability or retirement) benefits, the Department shall, at the request of the carrier/self-insured, reconsider eligibility for benefits and calculate an offset to modify benefits accordingly.

10. If the prescription drug dispensed outside of a retail, mail order, or institutional pharmacy is for a repackaged drug, the maximum reimbursement amount shall be calculated utilizing the average wholesale price set by the original manufacturer of the underlying drug, which may not be the manufacturer of the repackaged or relabeled drug.

If the National Drug Code (NDC) of the underlying drug cannot be determined from the billing, the maximum reimbursement amount shall be calculated utilizing the lowest cost, therapeutically equivalent drug.

Medications dispensed outside of a licensed pharmacy to a workers' compensation claimant may be reimbursed for a period no greater than 15 days from the date of injury. Refills of medications dispensed within 15 days from the date of injury will not be reimbursed.

11. The hearing test most proximate to the date of employee removal from a "noisy work area" as defined by OSHA standards, whether before or after such date and whether the employee is removed by reassignment, quit, termination, or retirement, shall be used to establish any loss of hearing claim.

12. 102.59, related to second injuries and the second injury fund, shall be repealed.

13. Management reserves the right to add/modify proposals.